MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

_____	)	
HEALTH CARE PROVIDER	)	IN RE: Medical Fee Dispute No: _____
	)	
vs.	)	Employee (Patient): _____
	)	
_____	)	Employee (Patient) Social Security No: _____
EMPLOYER	)	
	)	Date of Accident/Incident: _____
_____	)	
INSURER	)	Workers' Comp Injury No: _____

REQUEST FOR DISMISSAL OF APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENTS OF MEDICAL FEES

The undersigned party or parties hereby requests that the Division of Workers' Compensation of the State of Missouri dismiss its Application for Payment of Additional Reimbursements of Medical Fees on the following grounds:

☐ The medical fee dispute has been resolved or otherwise compromised and settled.
Date _____ Amount _____

☐ The dispute does not involve the type of medical fee dispute applicable to the administrative process involved in the filing of an Application for Payment of Additional Reimbursements of Medical Fees.

_____
Health Care Provider

_____
Health Care Provider's Attorney

_____
Address and Telephone

Date: _____

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the Request for Dismissal of Application for Payment of Additional Reimbursements of Medical Fees has been mailed by first-class mail, postage prepaid or hand delivered to _____ (name and address of opposing party or opposing party's attorney) this _____ day of _____, 20____.

_____
Health Care Provider or Health Care Provider's Attorney